ATTACHMENT 5
Sample ADA 2000 claim form for dental services

(Changes in claim form instructions are circled)

Dental Claim Form

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1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization # **1234567**
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): **Recipient, Im A.** | 9. Address | 10. City | 11. State

12. Date of Birth (MM/DD/YYYY): **MM / DD / YYYY** | 13. Patient ID #: **1234567890** | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code

17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____

18. Employer/School Name_____ Address_____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #

22. Subscriber/Employee Name (Last, First, Middle)

23. Address | 24. Phone Number ( )

25. City | 26. State | 27. Zip Code

28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Policy #

33. Other Subscriber's Name: **OI-P M-5**

34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name

37. Employer/School Name_____ Address_____

38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

40. Employer/School Name_____ Address_____

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: **I.M. Provider** | 43. Phone Number ( ) | 44. Provider ID #: **12345678** | 45. Dentist Soc. Sec. or T.I.N.

46. Address: **1 W. Williams St.** | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☒Office ☐Hosp. ☐ECF ☐Other **11**

50. City: **Anytown** | 51. State: **WI** | 52. Zip Code: **55555** | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☒No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____

55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: _____ Date of prior placement: _____

56. Is treatment result of occupational illness or injury? ☒No ☐ Yes Brief description and dates_____

57. Is treatment result of: ☐auto accident? ☐other accident? ☒neither Brief description and dates_____

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
MM DD YYYY				D5110	1	Complete upper denture	XXX.XX
MM DD YYYY	28	MOD		D2160	1	Amalgam	XX.XX

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	XXX.XX
Payment by other plan	XX.XX
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X I.M. Provider **87654321** **MM/DD/YYYY**

Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed | 64. City | 65. State | 66. Zip Code

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J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746